THE RECOVERY KERNEL

HOW TO RECOVER FROM 3-MMC

3-Methylmethcathinone · Metaphedrone

Using the Recovery Kernel Framework

Synthetic Cathinone / Novel Psychoactive Substance (NPS) — The Positional Isomer That Replaced Mephedrone

⚠ HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE | Crisis: call 911 or text 988

3-MMC'S DEFINING DANGER IS SPEED, NOT DOSE ALONE: A VERY SHORT DURATION OF EFFECT DRIVES COMPULSIVE REDOSING, AND CUMULATIVE CARDIOVASCULAR STRAIN ACROSS A BINGE — NOT ANY SINGLE DOSE — IS WHAT MOST OFTEN TURNS DANGEROUS.

A Note Before You Begin

This guide is a navigation instrument. It tells you which Recovery Kernel protocols to use, in what order, and why — specifically for 3-MMC (3-methylmethcathinone), a synthetic cathinone that rose to prominence as a direct replacement for mephedrone (4-MMC) after mephedrone was scheduled in most jurisdictions. The two compounds are positional isomers — the methyl group sits in a different place on the same basic structure — and they are often discussed interchangeably. They should not be. 3-MMC's pharmacokinetics are meaningfully different, and that difference is the center of both its appeal and its danger.

What happened to you was not weakness. Your brain has specific genetic architecture — COMT variants, DRD2 receptor density, MAOA activity — that shaped how strongly the compulsive redosing pattern took hold. 3-MMC's short duration of action means the biological 'want more' signal fires faster and more often per session than with almost any other cathinone. That is a pharmacokinetic fact about the molecule, not a character flaw in the person using it. This guide addresses both the biology of recovery and the specific behavioral trap this particular compound's speed creates.

Work through this guide in sequence. Do not skip ahead. Each section prepares the ground for the next.

🚨 MEDICAL EMERGENCY

GO TO AN EMERGENCY DEPARTMENT OR CALL 911 NOW IF YOU OR SOMEONE NEAR YOU HAS: chest pain, a racing or irregular heartbeat, a body temperature that feels dangerously high, seizure activity of any kind, severe agitation or paranoia that is escalating, or loss of consciousness.

These are signs of sympathomimetic toxicity — a genuine cardiovascular and neurological emergency that becomes more likely the longer a binge continues, because each redose adds to cumulative cardiovascular strain rather than starting from zero. If opioids, other stimulants, alcohol, or GHB were also used, tell paramedics or ER staff specifically — combination toxicity, not any single substance alone, is the leading pattern in 3-MMC-related deaths on record.

Section 1 — What 3-MMC Did to Your Brain and Body

You cannot navigate recovery without understanding the terrain. With 3-MMC, the terrain is defined less by any single pharmacological quirk and more by timing — how fast the compound arrives, how fast it leaves, and what that speed does to using behavior.

THE CENTURION — The Short-Fuse Cathinone

3-MMC acts as a monoamine releasing agent and reuptake inhibitor — potently releasing and blocking reuptake of dopamine and norepinephrine, with a moderate serotonin-releasing component layered on top, which gives it a mildly entactogenic, socially warm quality alongside its stimulant effects. Pharmacokinetic research places its plasma half-life at under an hour, with effects arriving within minutes of use. That combination — fast onset, fast offset — is the single most important fact about this compound's risk profile.

A drug that clears this quickly creates an unusually tight, unusually frequent loop between 'the effect is fading' and 'use again.' This is not simply a stronger craving in the ordinary sense — it is a pharmacokinetic architecture that produces more redosing decisions per hour than almost any other stimulant in this series. Each of those redoses adds to a cumulative cardiovascular load — heart rate, blood pressure, body temperature — that does not reset between doses the way the subjective high does. The danger in a 3-MMC binge is rarely any single dose. It is the arithmetic of many doses taken close together.

The Compound Comparison

Compound	Primary Mechanism	Duration	Defining Risk
Mephedrone (4-MMC)	Strong DAT/NET release, moderate SERT	Short, but longer than 3-MMC	Compulsive redosing, cardiovascular strain
3-MMC (Metaphedrone)	Strong DAT/NET release, moderate SERT	Very short — effects fade within roughly an hour	The fastest redosing cycle in the cathinone category; cumulative cardiovascular load across a binge
Methedrone	Weak DAT, strong SERT/NET	Long — roughly a day to clear	Narrow toxicity margin, serotonergic/MAOI interaction risk
Methamphetamine	DAT/NET release and reuptake block	Long — many hours per dose	Sustained binge duration, psychosis risk

⚠ CAUTION

This guide will not provide dosing thresholds, redosing intervals, or any administration guidance for 3-MMC. Because the compound's danger is driven by cumulative, session-level exposure rather than any single measured amount, there is no safe redosing interval to offer

— any number given here would misrepresent a genuinely unpredictable risk as a manageable one.

Injection Use and the Chemsex Context

3-MMC, like mephedrone before it, is used by injection ('slamming') in some chemsex settings, often alongside methamphetamine and GHB. This route carries its own serious risks independent of the cathinone itself — bloodborne virus transmission (HIV, hepatitis C), injection site infections, and vein damage — layered on top of the cardiovascular strain described above. If this applies to you, harm reduction services that provide sterile injecting equipment, regular BBV testing, and chemsex-specific support exist in most major cities and many operate anonymously. This guide does not provide injection technique instruction; it points you toward the services that can support you directly and safely.

Section 2 — Your Genomic Blueprint

The Recovery Kernel is built on a foundational principle: your genetics shaped your vulnerability and they shape your recovery. With 3-MMC, genetics intersects most directly with the compulsivity of the redosing pattern itself.

The DNA Panel for 3-MMC Recovery

THE CENTURION — The Genes Behind the Redosing Loop

These are the genetic variants most relevant to 3-MMC's fast-cycling mechanism, alongside the standard stimulant-recovery panel. You do not need all of them to proceed, but knowing your profile allows you to individualize the recovery protocol.

Gene / Variant	What It Governs	Relevance to 3-MMC
DRD2 (Taq1A)	Dopamine D2 receptor density	A1 allele carriers show reduced baseline receptor density; the very short window before 3-MMC's effect fades may intensify the drive to redose in this population specifically
COMT (Val158Met)	Dopamine and norepinephrine clearance rate	Warrior (Val/Val) profiles often report the fast, repeatable hit of 3-MMC as especially compelling — same framework as the core stimulant guide, calibrated for a faster cycle
MAOA (uVNTR / rs6323)	Monoamine oxidase A activity — baseline breakdown rate of dopamine, norepinephrine, serotonin	Faster baseline monoamine clearance may shorten the subjective high further, potentially reinforcing the redosing cycle this compound already drives
SLC6A4 (5-HTTLPR)	Serotonin transporter density and expression	Shapes the intensity of 3-MMC's moderate entactogenic component and general serotonergic sensitivity
MTHFR (C677T / A1298C)	Folate methylation, required for monoamine synthesis	Standard methylation-support relevance for rebuilding dopamine, serotonin, and norepinephrine supply during recovery

Testing options: Genomind, GeneSight, Genomic Life, or raw DNA from 23andMe/AncestryDNA interpreted through Genetic Lifehacks, StrateGene, or SelfDecode.

Reading Your Profile Before You Have Test Results

- Did you find yourself redosing every 30–60 minutes almost automatically, more than with other stimulants you've used? → Consistent with 3-MMC's short half-life interacting with a DRD2 deficit or Warrior COMT profile.
- Did sessions tend to run much longer than planned, with the end point never quite arriving? → The short-duration redosing loop described in Section 1 — not a willpower issue.
- Do you also struggle with depression, emotional blunting, or fatigue even when clean? → Likely MTHFR involvement — prioritize methylation support immediately.

Section 3 — The Detox Protocol

Because 3-MMC clears the body quickly, the comedown after a binge tends to arrive fast and hit hard — closer in character to a sharp crash than a gradual fade. The good news embedded in that fact: the most acute phase is also typically shorter than with longer-acting stimulants, provided the binge itself has ended.

The Withdrawal Timeline

Phase	Typical Window	What's Happening
Acute crash	Hours after last dose of a binge	Sharp fatigue, low mood, and often intense residual craving to redose — this is the highest-risk window for continuing the binge rather than stopping
Early withdrawal	Days 1–5	Irritability, anxiety, disrupted sleep, appetite changes; cardiovascular symptoms (racing heart, palpitations) can persist for a day or two after a heavy binge and merit medical attention if severe
Stabilization	Weeks 1–4	Sleep and appetite gradually normalizing; mood remains fragile
PAWS	Months 1–6	Intermittent low mood and craving, often triggered by cues associated with binge sessions

BEING HEARD

If the hardest moment of quitting isn't the first day but the hour right after your last dose, when everything in you says 'one more' — that's not a lack of willpower. That's the exact mechanism Section 1 describes, firing at its most intense point. Getting through that specific hour, with support and away from the supply, is often the single hardest and most important part of the whole process.

Section 4 — Dopamine Reconstruction

This is the biological engine of recovery — rebuilding receptor density, dopamine synthesis capacity, and the methylation foundation that makes it all possible. Everything here: discuss with a physician before starting.

4.1 — The Methylation Foundation

5-methyltetrahydrofolate (5-MTHF), the active folate form, is what your brain can use directly for monoamine synthesis regardless of MTHFR status.

4.2 — Dopamine Precursor Support

The dopamine synthesis pathway runs phenylalanine → tyrosine → L-DOPA → dopamine. Precursor support follows the same framework as the core stimulant guide. Wait until eating is regular and acute withdrawal is stabilizing (typically several days minimum) before starting.

4.3 — Receptor Rehabilitation

D2 receptor upregulation happens automatically with abstinence; the goal is supporting and accelerating it. Given how many redosing cycles a 3-MMC binge can involve compared to longer-acting stimulants, receptor exposure across a heavy-use period can be unusually high relative to total drug consumed — worth keeping in mind when calibrating expectations for the reconstruction timeline.

4.4 — The Craving Interrupt Protocol

Because 3-MMC cravings can convert to redosing within minutes during active use, and can remain sharp in the hours just after stopping, this interrupt is built for a fast-acting craving.

- LOCATE IT IN THE BODY. Name the physical location specifically. This is a body event, not a command.
- IMMEDIATE PHYSICAL INTERRUPT. Something genuinely demanding — a fast walk, cold water on the face, push-ups — to compete with the signal in the first sixty seconds.
- MOVE AWAY FROM THE SUPPLY AND THE USE ENVIRONMENT. The single most important variable for a short-window craving like this one.
- MAKE CONTACT. Text or call one person from your support structure. Isolation is where a redosing decision happens fastest.
- 4-7-8 BREATHING. Four to eight cycles once the initial urgency has been interrupted.
- DOCUMENT IT. Trigger, intensity, what you did, what happened. Patterns become data.

Section 5 — Rebuilding Sleep

Stimulant binges built around rapid redosing are especially disruptive to sleep architecture, both because of the direct arousal effect and because binge sessions

frequently run through the night entirely. Rebuilding sleep is a medical priority, not a lifestyle suggestion.

- Consistent sleep-wake timing, even when sleep itself is poor early on.
- Magnesium glycinate and L-theanine are commonly used non-stimulating supports for early-recovery sleep.

Refer to Protocol 09 (Sleep Architecture) in the main Compendium for the full behavioral and environmental sleep protocol.

Section 6 — Porting the Addiction: Same Engine, Different Address

THE CENTURION — What 3-MMC Was Actually Providing

The Warrior-constitution intensity architecture from the core stimulant guide applies directly here — but 3-MMC's specific appeal often centers on repeatability: the ability to re-trigger the peak experience again and again within a single session. The natural-reward replacement needs a genuine mastery curve with real, frequent feedback, not just one high-intensity outlet.

6.1 — The Function Audit

What did 3-MMC actually provide? Energy, sociability, confidence, an easily repeatable peak experience, escape from boredom or a flat baseline. Every item on that list is a real need that did not disappear when the drug did.

6.2 — Building the Architecture

- One high-intensity physical challenge with frequent, repeatable feedback — competitive sport, interval training, martial arts.
- A skill with a fast, visible feedback loop — music, a craft, a game with a mastery ladder — that scratches the 'repeatable peak' itch safely.
- Genuine social connection built around shared activity, not just proximity.

Section 7 — Navigating the Recovery Kernel: Your Protocol Map

Stage	Compendium Protocol	Purpose
Immediate	Protocol 01 — Shelter & Stabilization	Safety and grounding in the first 72 hours
Week 1	Protocol 09 — Sleep Architecture	Rebuilding sleep as a medical priority
Weeks 1–4	Protocol 05 — Environmental Redesign	Reducing access and cue exposure, especially session-triggering environments
Ongoing	Protocol 28 — Natural Addiction Porting (C-28)	Redirecting the underlying drive toward real-world targets

Stage	Compendium Protocol	Purpose
Ongoing	Compendium Section 15 — RDS / COMT Phenotyping	Individualizing the biological protocol

Section 8 — The Medical Support Layer

THE CENTURION — The Pharmacological Bridge — What Exists and How It Fits

There is no FDA-approved medication specifically for synthetic cathinone use disorder. Medications sometimes used off-label for stimulant use disorder more broadly (bupropion, N-acetylcysteine) may be discussed with a physician; whether they're appropriate depends on your full medical and use history, including any cardiovascular symptoms experienced during binges — these deserve their own evaluation independent of the addiction question.

Bring this guide's genomic panel (Section 2) to your physician, along with an honest account of your binge pattern (typical session length, frequency, route of administration) and any cardiovascular symptoms you noticed during use.

A Final Word

THE CENTURION — You Are Not the Character

The pull to chase the peak again, the second it started to fade — that system is not broken. It found a compound engineered, structurally, to make that loop as tight as possible. The work ahead is building a version of that repeatable peak that doesn't carry a cardiovascular price tag, and doesn't need to happen every thirty minutes to feel real.

SANCTUARY

Every hour you get further from the last redose is real progress, even if it doesn't feel dramatic. This is a fast-cycling drug, and the recovery it demands rewards the same thing consistency always rewards — steady, unglamorous repetition, which is the one thing 3-MMC itself could never actually give you.

END OF GUIDE — HOW TO RECOVER FROM 3-MMC

Harm Reduction Resource — Not Medical Advice — Not a Substitute for Emergency Care

Crisis: call or text 988 | Emergency: 911 | SAMHSA: 1-800-662-4357

See the companion guide: Discontinuance Protocol — 3-MMC, Compulsive Redosing, and Polypharmacy